

## **Hospital Inpatient Validation**

### **Invalid Record Selection/Incorrect Date(s) of Service Details**

The Hospital Data Validation Case Selection Report, available from My QualityNet (formally QualityNet Exchange), includes the patient identifiers for the five medical records selected for validation. These identifiers are dependent upon what the provider and/or its vendor submitted to the QIO Clinical Warehouse. The CDAC (BDS-York) information (request and cover sheets) for each provider is obtained directly from the QIO Clinical Warehouse.

Once a medical record is received by the CDAC, it is CMS's policy to prohibit providers from being able to add pages or replace the medical record in its entirety. When abstraction begins by the CDAC, the abstractor reviews the received medical record and compares it to the identifiers on the cover sheet (which were originally obtained from the locked warehouse).

When the patient's name (if submitted) isn't an exact match, but all other submitted patient identifier (i.e., Birth Date, admission date and discharge date, as well as the social security number, medical record number and/or account number if submitted) is a match, it is considered valid record for purposes of CDAC validation reabstraction of the quality measure data elements. Example: Submitted warehouse file states the patient's name is "Al Waterhouse," but the medical record documentation received by the CDAC states the patient's name is "Alfred Waterhouse". This case will continue to have the remaining identifier information (Birth Date, Admission Date) reviewed to ensure the correct medical record was received.

### **Invalid Record Selection**

In order to be considered a "valid record," the birth year has to be an exact match when there is no other information to verify that it is the correct patient and record. Records not considered "valid" will receive mismatches for all of the submitted elements and will continue to be classified as "Invalid Record Sent."

If the record was not an Acute Inpatient Level of Care stay (Emergency Department only, Skilled Care only) it will be considered an Invalid Record.

### **Incorrect Dates of Service**

When there are differences in Admission and Discharge Dates between what the hospital submitted and the CDAC abstracts, the CDAC will follow the CMS instructions below:

Admission Date (admit-date)

1) CDAC abstracted date is more than 3 days later than the hospital submitted date; or 2) CDAC abstracted date is more than 1 day earlier than the hospital submitted date. For example, the warehouse contains a hospital submitted abstraction with the Admission Date 11/05/07. If the CDAC abstracted Admission Date falls between 11/04/07 and 11/08/07, the date will be considered valid and the record will be abstracted by CDAC. Any dates outside this range will cause the record to be considered an "Incorrect Date(s) of Service" record.

### Discharge Date (discharge-date)

1) CDAC abstracted date is more than 1 day earlier or 1 day later than the hospital submitted date. For example, the warehouse contains a hospital submitted abstraction with the Discharge Date 11/13/07. If the CDAC abstracted Discharge Date falls between 11/12/07 and 11/14/07, the date will be considered valid and the record will be abstracted by CDAC. Dates outside this range will cause the record to be considered an “Incorrect Date(s) of Service” record.

### Intra-campus Transfers

Patients transferred from one acute care hospital to another acute care hospital that is within the same health care system or multi-campus hospitals and share the same CMS Certification Number (CCN) should be abstracted as one episode of care. Hospitals that submit an intra-campus transfer episode as a single acute care inpatient episode of care to the QIO Clinical Warehouse are required to submit medical record documentation to CDAC for the entire acute care inpatient episode from all campuses included in the episode of care. CDAC will utilize the invalid record selection criteria outlined in this document for the single consolidated episode of care to determine whether the case is a valid record. Updated 081308 – Implement with 4Q07 Discharges.

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